SOMERS
PEDIATRIC DENTISTRY

Child's Name_____ Date _____

Home Address_____ Phone _____Cell_____

City_____State_____Zip Code_____

Sex ☐ M ☐ F Age _____ Birth Date _____ Nickname _____

Names and Ages of Brothers and Sisters _____

Hobbies, Pets, Favorite TV Shows, etc._____

Person Responsible for this Account _____Email Address_____

Parents: ❑ Married ❑ Single ❑ Separated ❑ Widowed ❑ Divorced

Whom may we thank for referring you? _____

DENTAL HISTORY

Reason for this visit (1st examination, check-up, toothache, etc.) _____

Is your child currently nursing or drinking from a bottle?_____

Has your child ever had an injury to the mouth, teeth or jaws (fall, blow, etc.)? _____

How long since last visit to a dentist? _____

Was the dental experience pleasant or unpleasant? _____

If unpleasant, how did he/she react? _____

Has your child had Novocain? No ☐ Yes ☐ Has your child had laughing gas? No ☐ Yes ☐

Does your child have any history of thumb or lip sucking, pacifier, nail or lip biting? If yes, please explain:

_____

Does your child use fluoride toothpaste? _____Does your child take a fluoride vitamin?_____

MEDICAL HISTORY

Child's physician/pediatrician_____Phone_____

Address_____City_____State_____Zip Code_____

Is your child in good health? _____ Is your child taking any medications? _____

Is your child allergic to any medications? _____ **General allergies**? _____

If you answer yes to any of the following please circle the condition

Any history of cerebral palsy, seizures, fainting, or loss of consciousness?	No ☐	Yes ☐
Any Sensory disorders, ADHD, Autism, or Downs syndrome?	No ☐	Yes ☐
Any history of congenital heart disease, heart murmur or rheumatic fever?	No ☐	Yes ☐
Has any heart surgery been done or recommended?	No ☐	Yes ☐
Has your child ever had a blood transfusion?	No ☐	Yes ☐
Any history of anemia or sickle cell disease?	No ☐	Yes ☐
Does your child bruise easily or bleed excessively from small cuts?	No ☐	Yes ☐
Any history of pneumonia, cystic fibrosis, asthma, or difficulty breathing?	No ☐	Yes ☐
Any history of stomach, intestinal, kidney or liver problems?	No ☐	Yes ☐
Any history of hepatitis?	No ☐	Yes ☐
Any history of diabetes?	No ☐	Yes ☐
Any history of thyroid disease or other glandular disorders?	No ☐	Yes ☐
Has your child ever been hospitalized?	No ☐	Yes ☐
(If yes, please explain) _____		
Is your child up to date with immunizations? (DPT,IPV,MMR,Hib,HepB)	No ☐	Yes ☐

List of surgeries or related problem?_____

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INSURANCE AND CONSENT

Father's/ Spouse/ Guardian Name:	Mother's/ Spouse/ Guardian Name:
Address (if different from Patient's):	Address (if different from Patient's):
Home Phone_____ Work Phone_____	Home Phone_____ Work Phone_____
Employer:	Employer:
Soc Sec# _____ Birthdate _____	Soc Sec# _____ Birthdate _____
Do you have dental insurance for minor Child? □ Yes □ No	Do you have dental insurance for minor Child? □ Yes □ No
Plan Name:	Plan Name:
Plan Phone Number:	Plan Phone Number:
Plan Address:	Plan Address:
Plan Group Number:	Plan Group Number:
Plan Policy Number:	Plan Policy Number:

CONSENT:

1. The undersigned hereby authorizes the doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor for a thorough diagnosis of the patient's dental needs.
2. I also authorize the doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient)_____. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that the doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. To the best of my knowledge, the above information is complete and accurate. I understand that even though I may have some type of dental insurance coverage, I am responsible for payment services rendered. I authorize release of any information to my insurance company related to my dental claims.

_____ _____

Parent/Guardian Signature Date Dentist Signature Date

DENTIST'S COMMENTS:

Medical consultation recommended? No____ Yes ____ Date Requested _____

Purpose for consultation:_____

SEMIANNUAL REVIEW OF MEDICAL-DENTAL HISTORY: If history remains essentially unchanged, sign below:

_____ _____

Parent/Guardian Signature Date Dentist Signature Date

_____ _____

Parent/Guardian Signature Date Dentist Signature Date

_____ _____

Parent/Guardian Signature Date Dentist Signature Date

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374 Route 116 | Somers, NY 10589

FINANCIAL POLICY

We accept assignment of some insurance plans. However, you must clearly understand and agree that:

1. Your insurance policy is a contract between you, your employer, and the insurance company; our relationship is with you, **NOT** the insurance company.

2. **ALL** charges incurred are charged directly to **YOU** and you are personally responsible for payment. Deductibles and co-payments are due at the time of treatment. We estimate your co-payments according to your policy. We **DO NOT** in any way guarantee that your insurance will pay this amount.

3. If the insurance company doesn't pay within a reasonable amount of time, it is required that you pay the balance due. After 60 days there will be a re-billing fee of 5% that will be added to your account each month until the account is paid in full.

4. Your Insurance coverage must be verified before the initial visit. If coverage cannot be verified before your child's visit then payment (cash, check, or credit card) is expected at the time of service.

5. **For separated or divorced parents:** the parent who brings the child to the office is legally responsible for payment of fees charged for that child's care. If another agrees to payment responsibility, that person must provide a notarized acknowledgment in writing of their desire to pay for care. It is the responsibility of the person bringing the child to the office to obtain a written agreement and to inform the other person of care being provided.

6. **I understand that Dr. Dowling sets aside dedicated time in her office for my child's dental appointment. If I find it is necessary to cancel, I will provide a 24 hour advance notice. Without proper notice I understand there will be a $75.oo fee per appointment that is scheduled.**

We understand that temporary financial problems may occur. We encourage you to communicate any such problems so that we can assist you in the management of your account.

Patient Name_____

Patient/Guardian Signature_____

Date_____

TEL: (914) 358-1225 FAX (914) 358-1227

Somerspediatricdentistry.com

PATIENT HIPAA AWARENESS

With my permission, Somers Pediatric Dentistry may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Somers Pediatric Dentistry Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Somers Pediatric Dentistry reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission, the office of Somers Pediatric Dentistry may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my permission, the office of Somers Pediatric Dentistry may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and or Confidential.

With my permission, the office of Somers Pediatric Dentistry may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Somers Pediatric Dentistry restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this, I am allowing Somers Pediatric Dentistry to use and disclosure my PHI for TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

_____

Signature of Patient or Legal Guardian

_____ _____

Print Name of Patient or Legal Guardian Date